Testimony Before the Little Hoover Commission
Hearing on Drug Abuse Treatment
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Submitted by Elizabeth Stanley-Salazar
Vice President, Director of Public Policy
Phoenix Houses of California

Thank you for convening this critical set of hearings and for inviting me here today. In addition to serving as the Vice President, Director of Public Policy, for Phoenix Houses of California, I appear today as a member of the board of directors of the California Association of Alcohol and Drug Program Executives (CAADPE), a professional membership organization of 75 community-based substance abuse treatment programs representing residential, outpatient, methadone maintenance, and prevention programs across the state.

Phoenix House is California's – and the nation's – largest nonprofit substance abuse services provider. Since our founding 35 years ago, we have treated over 100,000 women, men, and youth for substance involvement in eight states. The vast majority of our work has been in long-term residential treatment for the most hard-core substance abusers, whether adults, adolescents, or the incarcerated. We have been providing comprehensive treatment services in California for the past 23 years, during which time we have served over 10,000 adults, youth, and their families.

From our beginnings Phoenix House has been a pioneer in the therapeutic community (or "TC") modality of treatment, demonstrating leadership particularly in the successful modification of the TC to serve diverse substance abusing populations such as women with children, the homeless, and the mentally ill. Phoenix House is also a leading advocate for drug treatment and its effectiveness, conducting significant research to help inform policy-makers and the general public about the systemic causes of substance abuse, its interrelatedness with the nation's most intractable social problems, and the overall social benefit and cost-effectiveness of treatment.

The Substance Abuse Treatment Gap

Over the past seven years, there has been a significant increase in the demand for community-based treatment, due in large part to a number of State and Federal policy initiatives that finally recognize substance abuse as a critical component of many social problems and substance abuse treatment as a cost-effective solution.[1]

- The advent of perinatal programs (of which there are now almost 250 statewide) to serve pregnant and parenting women – based on the "crack baby" phenomenon and the recognition that parental substance abuse is at the root of the vast majority of dependency court cases.

- As part of the great welfare reform effort of the mid-90s, CalWORKs now funnels approximately 1000 new clients into treatment each year. (Far more could be served were it not for draconian elements of these policies making individuals convicted of drug-related felonies ineligible for most forms of public assistance.)

- Beginning in the mid-1990s, 146 drug courts have been developed in numerous jurisdictions throughout the State, sending several thousand participants annually to various community-based treatment programs.

- The California Department of Corrections' treatment project – which began in earnest with the opening of the California Substance Abuse Treatment Facility and State Prison at Corcoran in 1997 – has created over 8000 in-prison therapeutic community treatment beds in the state prison system. Each of these inmates is expected to participate in community-based aftercare after release (though this phase of the program is voluntary – and, in fact, lack of availability of community-based treatment is one of the reasons why participation in continuing care has historically been so low). This figure does not include the cognitive skills, social model, and educational programs existing in many State institutions, nor does it include the programs that have been developed in County jails such as Theo Lacy in Orange County and Twin Towers in Los Angeles.

- Passed in November 2000, Proposition 36 has created the need for many thousand additional treatment slots per year for nonviolent offenders. The law itself estimates 36,000 new clients per year, and Counties are just starting to see what levels of new demand are being created.

Unfortunately, treatment capacity in the State has not been able to grow rapidly enough to accommodate this increased demand – particularly for residential services, which are necessary for substance abusers with the most significant disorders. While the number of licensed programs has been increasing in recent years, a large number of the new beds are in small programs of six residents and under (which, by dint of their size, bypass many regulations and other requirements). Moreover, a great many community-based programs have closed in recent years, significantly reducing the impact of the new programs that have opened.

Existing community-based treatment programs are filled to capacity. For example, the 85-bed Phoenix House Orange County adult residential treatment program currently has a waiting list of over 70 clients. Sadly, most waiting-list clients never enter treatment – substance abusers are rarely highly motivated to participate in treatment, and such barriers usually cause them to lose what little or fleeting motivation they may have been able to muster.

There is also a significant need for programs that are expert at dealing with substance abusers with more complex disorders and/or histories. For example, the criminally involved substance abuser – at whom many of the new policy initiatives have been aimed

– is a significantly more challenging client (with low literacy, lack of vocational and life skills, etc – not to mention those criminal justice clients who require additional expertise: those with histories of violence, the dually diagnosed, sex offenders, etc). The need is equally great for programs designed to work with women (especially parenting women), various cultural/ethnic populations, and those of varying sexual orientations and gender identities. This fall Phoenix House testified before the California Legislative Women's Caucus's Hearing on Incarcerated Mothers to outline the issues specifically related to community-based treatment for criminally involved women – as that testimony outlines additional issues specifically relevant to that population, we have attached it for your reference.

The existing system of care was built for a fraction of the current clients at a fraction of the acuity. Contributing to providers' inability to keep pace with the need is the extremely limited authority of the State's Department of Alcohol and Drug Programs (DADP). An agency that was created primarily for oversight of the Federal Substance Abuse Prevention and Treatment Block Grant to our Counties, DADP has not been in the position to develop the infrastructure (particularly in terms of capacity expansion and workforce development), conduct the strategic planning, or drive the legislation and regulation necessary to create a modern and comprehensive treatment system throughout the state.

Barriers to Opening Treatment Programs in the Community

Providers have not been able to open more programs to meet the increased demand for a great many common reasons – most of them logistic. (It should be noted that the following discussion pertains primarily to residential treatment programs.) First, there are few existing buildings in most communities that are appropriate for – or can easily be converted to – substance abuse treatment. There are also a limited number of areas in most cities in which substance abuse treatment can be established, whether by converting a building to this use or by building a new facility. Those areas in which prospects are usually best (commercial and industrial zones) are generally the least conducive to treatment – let alone accessible to clients and their families.

Furthermore, acquisition, conversion, construction, and even expansion of facilities are subject to an extended and often arduous process involving city planning and zoning departments. The most challenging component of this process is usually the approval of the Conditional Use Permit (CUP) by the Zoning Administrator, most often solely because of the requirement for community input. Residents and business owners tend to be aggressively unsupportive of establishing or expanding substance abuse treatment in their communities, usually due to pervasive stereotyped fears of substance abuse and abusers

- Relatively minor changes in the use of the building (such as being able to include individuals with even mild psychiatric diagnoses or parolees in existing programs) are often subject to public hearings in order to modify the CUP.

- While each city's Planning Department has generally established a set of global conditions for the types of facilities allowable in each zone in its jurisdiction, local residents and businesses often demand the inclusion of individualized conditions on the CUP that can be onerous on property holders and program operators. These conditions can include everything from the number and type of parking spaces and garbage containers, to the height and type of masonry or landscaping, to the hours in which programming can take place out-of-doors. Limits on the numbers and types of clients a community will agree to also often make operating the building as a treatment facility untenable – either financially, clinically, or both.

- While CUPs are frequently granted for prolonged periods (ten years), it is not uncommon for a permit on a contested property to be given a three- or even one-year term. Submitting to public hearings on such a frequent basis – allowing any one incident to become a "call to arms" for the neighborhood – can also make operation impossible.

- A facility located on the border of two cities must go through the CUP approval process before each Zoning Administrator – who generally do not coordinate their concerns, processes, or conditions with one another.

- It is not uncommon for community members to mount aggressive, even fear-mongering campaigns against the proposed establishment of a new treatment program in their neighborhood. Intimidation is another not infrequently used tactic. Furthermore, the history of the building and the neighborhood – factors over which the treatment provider has no control, either in the past or for the future – are also often involved.

- All of this is makes it extremely difficult to purchase or rent a building when the outcome of the CUP process is so questionable. Moreover, it must be kept in mind that this permitting gauntlet exists *in addition to* the numerous licensing, permitting, and certification processes required for each program by many different State, County, and City agencies (eg, business license, certificate of occupancy, public health license, fire clearance, annual fire permit, substance abuse treatment certificate, group home license, etc).

Phoenix House is currently exploring undergoing this process at one of our Southern California facilities. In addition to the building we are currently using, we have had a vacant building on the property since acquiring it, which we are now considering converting to a residential treatment facility for women and their children. We were informed in February by our advisors that this process will take at least three years and possibly hundreds of thousands of dollars – before we can even begin renovation.

Process	Timeframe	Assoc. Cost
Mitigated Negative Declaration or Environmental Impact Report	6+ months (MND) up to 12-18 months (EIR)	$50,000 or $500,000

(cont)	Process	Timeframe
	Approval of Application for Use Permit	12 + months from submission
	CUP Hearing and Approval Process	12-18 months

As a result of these conditions, there has been a significant increase in the number of small treatment homes (six beds and under, which are not held to the same requirements), both licensed and unlicensed. This, in turn, has led to numerous initiatives by cities, Sheriff's Departments, and others to succumb to community pressure to develop and promulgate their own new ordinances and restrictions regarding where these facilities can be placed and how they operate (for example, Orange County's recently proposed Adult Alcohol and Drug Sober Living Facilities Certification Guidelines). The League of Cities and other groups have been instrumental in assisting local jurisdictions with this process, even attempting to have alcohol and drug abuse excluded from its current coverage under the Federal Americans with Disabilities Act – highlighting the need for the State to engage in a dialog with them and other key stakeholders to resolve this issue.

Treatment Standards

Numerous systems have been established in order to assure substance abuse treatment program quality, however, they are outdated, competing, conflicting, and fragmented. They also do not necessarily assure the application of best practices and the delivery of high quality treatment services. Current structures include:

- *Program Certification and Licensure* by the California Department of Alcohol and Drug Programs (DADP) – residential licensure is mandatory, but outpatient certification is only voluntary;

- *Third-Party Accreditation* such as by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Rehabilitation Accreditation Commission (CARF);

- *Program Accreditation* for particular modalities of treatment, usually through membership organizations such as the California Association of Addiction Recovery Resources (CAARR);

- *Staff Certification* via professional organizations such as the California Association of Alcohol and Drug Abuse Counselors (CAADAC) or the California Association of Addiction Recovery Resources (CAARR) – though nine such organizations are recognized by the State, all operate without DADP oversight or uniform standards;

- *Contract and Placement Agency Monitoring* by any Federal, State, County, or City agency that provides funding or makes referrals to the program – all of which operate without coordination or interagency review; and,

- *Internal or Peer Review* to accepted standards in the field by organization management – often through processes supported and/or created by membership organizations such as Therapeutic Communities of America (TCA), expert in the particular modality of treatment provided.

While some of these can individually be seen as having a vested interest in a positive review of the program in question, the right combination of these processes will ensure that clients are well served. The treatment industry would therefore be extremely well served by the State Department of Alcohol and Drug Programs: (1) setting *uniform, relevant, and specific* treatment standards to reduce the dissonance between these mainly voluntary and somewhat arbitrarily applied systems; and (2) creating a common data system that eliminates the fragmentation, duplication, and gaps within the current system.

Youth Issues

Of the 750 clients Phoenix House now serves in the state each day in community-based programs (in addition to 1600 incarcerated clients), over 450 are youth and families in Southern California. We have also created specialized programs such as assessment and treatment management services for the San Diego County Juvenile Delinquency Drug Court, and program development, implementation and ongoing staff training for therapeutic communities operated within juvenile halls in Orange and San Diego counties. We have therefore been asked to outline in this testimony some of the critical issues for service provision to adolescents.

Despite a shared belief that our children are our future, research on adolescent substance abuse and related issues is warning us that more and more, our children are at risk of having no future at all. Not only has substance abuse among adolescents increased dramatically in recent years, children are trying drugs at younger and younger ages and the drugs available are significantly more potent than in years past. At the same time as these alarming developments in drug use, the educational, behavioral, emotional, and familial problems suffered by substance-involved adolescents are far more severe than those characterizing drug-abusing youth just a few years ago. These trends are not only disheartening, but they are leading to the decimation of our inner cities and other neglected communities.

By the time they reach our residential treatment programs for substance abuse, they have usually experienced tremendous upheaval and trauma, such as physical, sexual, and emotional abuse; school failure – often brought on by learning difficulties and/or mental health issues; dysfunctional home lives; frequent runaways; pregnancy and parenting; and various forms of victimization. They also become perpetrators, engaging in violence, gang activity, and other types of delinquent behavior. Substance abuse rates among juvenile offenders are as much as ten times higher than the rates among their peers not involved in the justice system, and psychiatric problems occur between six and nine times more often (between 50% and 75% of incarcerated adolescents are estimated to have diagnosable mental health disorders).[2]

Substance abuse interferes with the important physical and psychosocial maturation processes that characterize adolescence. It not only harms young minds and bodies, it leads to poor decision-making with devastating consequences. In addition to violent trauma, substance-abusing adolescents are at significant risk of such serious health consequences as HIV and STDs, tuberculosis, and hepatitis – and in the long term, developmental and neurological damage, cirrhosis, diabetes, high blood pressure, and the various consequences of poor nutrition.

Because these youth often come from the most distressed populations within our communities, it is difficult to differentiate among the many social factors that both contribute to and stem from their substance abuse. It is well known, however, that these factors include poverty, gang involvement, limited English capability, learning disabilities, lack of employment and/or pre-employment skills, homelessness and substandard housing, mental health issues, immigration status, racism and discrimination (including toward sexual orientation/gender identity), family instability, parental addiction, abuse, neglect, and despair.

Unfortunately, the social services system that was created to protect and aid these youth is not keeping pace with their needs. Not only are services inadequate in terms of capacity – the most optimistic surveys project that only twenty percent of adolescents requiring treatment receive it[3] – the limited services that are available are fragmented among themselves and disconnected from one another. Because of the inadequacy of resources, almost all but the most disordered (or economically advantaged) teens go unserved: the majority of youth who receive treatment in Southern California – particularly residential services – are allowed access to those services only through their involvement in the juvenile justice system. That an adolescent and his or her family need to reach that level of dysfunctionality before they can receive assistance – often after having been shuttled among systems and services without receiving appropriate earlier intervention – is nothing short of a travesty. Meanwhile, the costs to society of this reality, in both human and financial terms, are staggering.

Even those adolescents who do receive services, however, are not getting enough of them. At the same time as our youth's needs are becoming more exigent, funders are demanding reduced lengths and intensities of intervention in order to stretch the limited dollars they do have – often in clear contravention of acknowledged best practices for effective treatment.[4] We cannot continue to allow increased need to turn into decreased services – our children, and our society, will fail. The larger community's lack of understanding of substance abuse – and that treatment does, in fact, work – contributes to this sad state of affairs.

True, there have been some recent changes for the better. Three years ago the State of California allocated a new $20 million to adolescent treatment in the counties; a portion is also being used to develop our first-ever state guidelines for adolescent treatment. But these expansion funds were significantly reduced in the current year's budget – well before the energy and security crises – and most of the local initiatives planned with these dollars in the past two years continue to be bogged down by bureaucracy, operational difficulties, budgetary crises, and institutional myopia. Furthermore, Proposition 36, the most far-reaching substance abuse initiative in our state's history, entirely ignores adolescents. The

few new youth treatment initiatives that are being introduced are primarily emanating from the juvenile justice system, which – even with the best intentions – still has a punitive orientation. In short, *there is still no coherent public policy for adolescent substance abuse treatment*, let alone the funding to support it.

The July 13, 1999, Legislative Analyst's report *Substance Abuse Treatment in California* calls for a significant increase in funding for drug treatment services, particularly for adolescents. It also calls for eliminating the systemic barriers to the treatment that does exist. Among these barriers are categorical funding streams that do not allow for the provision of the comprehensive services that are required by youth with such complex backgrounds and needs.

Moving Forward

There is significant unmet demand for community-based substance abuse treatment services throughout California, driven in large part by the variety of relatively recent public policy initiatives discussed above. However, because this increase in demand is built on a weak and outdated infrastructure, the barriers to meeting this new demand are so significant that treatment providers and their professional associations need leadership from the State to overcome them. Positions the Little Hoover Commission might take that would address a majority of the barriers facing treatment providers include:

- Recommending increased funding for treatment services beyond the Federal Block Grant and limited corrections-based initiatives – particularly funding that will help maximize targeted federal funds, promote the "no wrong door" concept of treatment[5], and assist with providers' efforts for workforce development.

- Advocating for the issuance of emergency regulations to enable circumnavigation of the usual Conditional Use Permit process for the specific purpose of establishing licensed residential substance abuse treatment facilities and other programs of high need in the public interest.

- Proposing expanding the mandate of the State Department of Alcohol and Drug Programs to a significantly more active role, allowing for true policy leadership and such changes as the setting of uniform, relevant, and specific treatment standards to which all publicly funded providers would be required to adhere.

- Urging revision to the Health and Safety Code that would eliminate its outdated and conflicting language; support empirically based, effective treatment services; and create an infrastructure that will support capacity growth.

- Supporting efforts to make sure that the treatment Californians receive ensures their likelihood of success. Funding for all treatment initiatives must ensure that the treatment provided follows research-driven, "best practices" methodology. Examples include mandating continuing care in the community for parolees who have received

treatment in prison, ensuring that funding for continuing care – from all programs – includes monitoring and support for relapse, and fighting the managed-care-driven reductions in lengths of stay.

- Promote the building of a system of care for adolescent treatment in the State that would ensure the elimination of the policies that have created the counterproductive operating conditions for youth treatment described above. Examples include working with the state foster care system to increase their recognition of substance abuse practitioners in the rate classification structure to ensure appropriate reimbursement for the expert services they provide.

In the face of all these obstacles, the amount that has been accomplished by the treatment community in the past decade is remarkable – reducing substance abuse, crime, recidivism, and a number of other societal ills. With leadership, funding, and a commitment equal to the magnitude and impact of the problem, treatment agencies will have the tools they need to meet our societal mandates and significantly reduce substance abuse and its effects throughout the State.

Elizabeth Stanley-Salazar
Vice President, Director of Public Policy
Phoenix Houses of California, Inc.
11600 Eldridge Avenue
Lake View Terrace, CA 91342
818.896.1121, ext. 4401
818.896.4859 fax
lsalazar@phoenixhouse.org

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[1] The cost-effectiveness of substance abuse treatment has been repeatedly studied, commonly showing at least a seven dollar cost savings for every treatment dollar spent. *See, for example,* Gerstein, DR, Johnson, RA, Harwood, H, Fountain, D, Suter, N, and Malloy, K (1994). *Evaluating Recovery Services: The California Drug and Alcohol Treatment Assessment (CALDATA)*. State of California Department of Alcohol and Drug Programs, Publication No. ADP 94-628 and 94-629.

[2] *Kids, Drugs,& Crime: Quick Facts*, retrieved at www.reclaimingfutures.org/pgQfJuvJus.shtml.

[3] *Lack of Research, Capacity Plague Adolescent Treatment System*. Feature article by Bob Curley for Join Together Online (www.jointogether.org), May 15, 2001.

[4] Time and again, length of treatment has been shown to be directly correlated with treatment outcome: the longer an individual is exposed to treatment, the more likely s/he is to maintain long-term success. *See, for example,* Simpson, DD (1995). *Issues in Treatment Process and Services Research*. The International Journal of the Addictions, 30 (7): 875-879.

[5] Substance Abuse and Mental Health Services Administration (2000). *Improving Substance Abuse Treatment: The National Treatment Plan Initiative*. Department of Health and Human Services, Publication No. (SMA) 00-3480.